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Jessica L. Bailey-Wheaton, Esq., Editor
Todd A. Zigrang, MBA, MHA, FACHE, CVA, ASA, ABV, Publisher

CMS Proposes 2027 OPPS Rule: Renewed 340B Cuts

On July 2, 2026, the Centers for Medicare & Medicaid Services (CMS) released the proposed rule for the Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System for calendar year (CY) 2027.[1] Among other changes, the agency proposes a renewed reduction in reimbursement for drugs acquired under the 340B Drug Pricing Program, an expansion of site-neutral payment policies to certain imaging services, and continuation of the phased elimination of the Inpatient Only (IPO) List.[2] This Health Capital Topics article discusses these proposed updates and their implications for outpatient reimbursement.

For CY 2027, CMS proposes to increase payment rates under both the OPPS and the ASC Payment System by 2.4% for providers that meet applicable quality reporting requirements, reflecting a proposed 3.2% hospital market basket increase reduced by a 0.8 percentage point productivity adjustment.[3] The proposed 2.4% update is below the 2.6% increase finalized for 2026.[4] CMS estimates that the combined effect of all of the proposed policies would be a net increase of approximately 1.9% ($1.8 billion) in total OPPS payments, although that aggregate masks wide variation, as hospitals that rely heavily on the 340B program would see net payment reductions.[5]

The 340B Drug Pricing Program allows hospitals and clinics that serve low-income, medically underserved populations to purchase certain outpatient drugs at discounted prices and to receive Medicare reimbursement for those drugs under the OPPS, with the resulting margin helping covered entities extend limited resources across their patient populations.[6] Medicare has generally reimbursed Part B drugs at the drug's average sales price (ASP) plus 6%.[7] For 2027, CMS proposes to pay for 340B-acquired drugs at ASP minus 33.4%, with several hospital categories, including rural sole community hospitals (SCHs), exempt from the reduction.[8] Because the change must be budget neutral, CMS proposes an offsetting increase to the OPPS conversion factor for non-drug items and services, which it and industry analysts have estimated at 8.44%.[9] The agency estimates the reduced rate would lower drug payments under Traditional Medicare by $4.55 billion and beneficiary drug payments by $1.15 billion in the first year.[10]

The proposal marks the agency's second attempt to single out 340B hospitals for reduced drug reimbursement. In the 2018 OPPS final rule, CMS reduced the rate for 340B-acquired drugs to ASP minus 22.5%, applicable to 340B participants only.[11] Hospitals and hospital associations sued, and in 2022 the U.S. Supreme Court unanimously held in *American Hospital Association v. Becerra* that CMS had exceeded its statutory authority by varying reimbursement rates for a subgroup of hospitals without first conducting the survey of hospital drug acquisition costs that the statute requires before such a variation.[12] Following that ruling, CMS issued its 340B Final Remedy rule in November 2023, repaying the underpaid hospitals through a lump-sum payment and beginning to recoup the offsetting payments it had made to other hospitals.[13]

This time, CMS grounds the reduction in a survey it conducted from January 1, 2026, through April 7, 2026, under the statutory acquisition-cost survey provision, covering each separately payable drug acquired by hospitals paid under the OPPS.[14] The agency reports that the survey revealed significant disparities between acquisition costs for drugs obtained inside and outside the 340B program, and that in some instances the beneficiary coinsurance amount, typically 20% of the total payment, exceeded the total price the hospital paid for the drug.[15] Stakeholders have questioned the survey's representativeness, noting that it drew responses from roughly 1,300 hospitals, approximately 28.6% of all 340B hospitals.[16]

Separately, the proposed rule would accelerate CMS's recovery of the payments hospitals received under the invalidated 2018 policy. To maintain budget neutrality, CMS had raised non-drug payments to all hospitals from 2018 through 2022, producing an estimated $7.8 billion in excess non-drug payments now subject to recoupment; the November 2023 remedy set that recovery at a 0.5% annual reduction to the non-drug conversion factor beginning in 2026.[17] That pace was originally expected to take roughly 16 years.[18] For 2027, CMS proposes to raise the annual offset to 3%, which it estimates would complete the recovery in 2029 while reducing payments to affected providers by approximately $2.3 billion in 2027.[19] Hospital groups have opposed compressing the timeline, characterizing the accelerated offset as a clawback that penalizes hospitals for the agency's own error.[20]

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The proposed rule also expands CMS's site-neutral payment policies. Off-campus provider-based departments are hospital-owned outpatient facilities located away from a hospital's main campus. Under a November 2015 statutory change, departments that were not already furnishing services at that time are paid reduced rates based on the Medicare Physician Fee Schedule (MPFS), while those already in operation – termed "excepted" departments – continued to receive the higher OPPS rates for the same services.[21] CMS has moved to narrow that difference service by service, applying MPFS-equivalent rates rather than the higher OPPS rates to drug administration services furnished in excepted off-campus provider-based departments (PBDs) in the 2026 final rule, and proposing for 2027 to extend the same approach to imaging services furnished without contrast, again exempting rural SCHs.[22] CMS estimates the change would reduce Medicare Part B expenditures by approximately $260 million and beneficiary cost-sharing obligations by approximately $70 million in the first year.[23] The agency frames the policy as removing site-of-care payment differentials that can prompt health systems to shift services to higher-cost settings and to acquire independent physician practices in order to raise their Medicare prices.[24] Hospital groups counter that outpatient departments treat more complex patient populations and must maintain capabilities that lower-cost sites do not.[25]

CMS also continues the three-year phase-out of the IPO List, the set of procedures for which Medicare pays only in the inpatient setting. In this second year of the transition, the agency proposes to remove 638 services across a range of clinical areas so that Medicare would pay for them in the outpatient setting when clinically appropriate.[26] The proposal follows the removal of 285 mostly musculoskeletal procedures in 2026.[27]

Other provisions of the 2027 OPPS and ASC proposed rule include:

(1) Updating the methodology for the Overall Hospital Quality Star Rating to give greater weight to the Safety of Care measure group;[28]

(2) Permitting hospital accrediting organizations with deeming authority to assess hospitals' compliance with the Emergency Medical Treatment and Labor Act (EMTALA), which CMS states would reduce duplicative state investigations given that over 80% of hospitals are accredited by such organizations;[29] and

(3) Issuing a request for information on standardizing and improving the comparability of hospital price transparency data.[30]

Trade associations and professional societies reacted swiftly, and largely critically. The American Hospital Association (AHA) called the proposed 33.4% reduction a "shocking" cut that would make drugs less affordable for vulnerable patients, and characterized the accelerated recoupment as punishing 340B hospitals for the agency's own error.[31] The Association of American Medical Colleges (AAMC) said it was "deeply troubled," warning that the outpatient reductions, the 340B cut, and the accelerated recoupment would together have enduring effects on access to care at teaching hospitals, and it urged CMS not to finalize the proposals.[32] America's Essential Hospitals said the rule would take "an axe" to funding that supports safety-net hospitals and cast the site-neutral imaging change as "yet another cut" those hospitals cannot absorb.[33] 340B Health argued that the reduction would redirect revenue from safety-net providers to hospitals that do not participate in the program.[34] The Federation of American Hospitals, which represents for-profit hospitals, took a more mixed view, describing closer alignment of payments with hospitals' costs as a step toward a fairer system while opposing the accelerated recoupment as an unnecessary financial burden.[35]

CMS will accept comments on the proposed rule through August 31, 2026, and typically finalizes the rule in late fall.[36]

The 2027 proposal returns CMS to terrain the agency last occupied when the Supreme Court invalidated its prior 340B reduction. What distinguishes this attempt is the acquisition-cost survey CMS conducted expressly to supply the statutory predicate the Court found missing, though hospitals dispute whether a survey answered by a minority of 340B entities can bear that weight. Layered onto a compressed recoupment schedule and a widening site-neutral policy, the rule would redistribute outpatient dollars away from the hospitals most dependent on 340B and toward those with little or no program exposure. Whether that redistribution can withstand the legal scrutiny that undid its predecessor remains to be seen.

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Todd A. Zigrang, MBA, MHA, FACHE, CVA, ASA, ABV, is the President of **HEALTH CAPITAL CONSULTANTS** (HCC), where he focuses on the areas of valuation and financial analysis for hospitals, physician practices, and other healthcare enterprises. Mr. Zigrang has over 30 years of experience providing valuation, financial, transaction and strategic advisory services nationwide in over 2,500 transactions and joint ventures. Mr. Zigrang is also considered an expert in the field of healthcare compensation for physicians, executives and other professionals.

Mr. Zigrang is the co-author of "*The Adviser's Guide to Healthcare - 2nd Edition*" [AICPA - 2015], numerous chapters in legal treatises and anthologies, and peer-reviewed and industry articles such as: *The Guide to Valuing Physician Compensation and Healthcare Service Arrangements* (BVR/AHLA); *The Accountant's Business Manual* (AICPA); V*aluing Professional Practices and Licenses* (Aspen Publishers); *Valuation Strategies; Business Appraisal Practice*; and, *NACVA QuickRead*. Additionally, Mr. Zigrang has served as faculty before professional and trade associations such as the American Society of Appraisers (ASA); the National Association of Certified Valuators and Analysts (NACVA); the American Health Lawyers Association (AHLA); the American Bar Association (ABA); the Association of International Certified Professional Accountants (AICPA); the Physician Hospitals of America (PHA); the Institute of Business Appraisers (IBA); the Healthcare Financial Management Association (HFMA); and, the CPA Leadership Institute. He also serves on the Editorial Board of The Value Examiner and QuickRead, both of which are published by NACVA.

Mr. Zigrang holds a Master of Science in Health Administration (MHA) and a Master of Business Administration (MBA) from the University of Missouri at Columbia. He is a Fellow of the American College of Healthcare Executives (FACHE) and holds the Certified Valuation Analyst (CVA) designation from NACVA. Mr. Zigrang also holds the Accredited in Business Valuation (ABV) designation from AICPA, and the Accredited Senior Appraiser (ASA) designation from the American Society of Appraisers, where he has served as President of the St. Louis Chapter. He is also a member of the America Association of Provider Compensation Professionals (AAPCP), AHLA, AICPA, NACVA, NSCHBC, and, the Society of OMS Administrators (SOMSA).

Jessica L. Bailey-Wheaton, Esq., is Senior Vice President and General Counsel of HCC. Her work focuses on the areas of Certificate of Need (CON) preparation and consulting, as well as project management and consulting services related to the impact of both federal and state regulations on healthcare transactions. In that role, Ms. Bailey-Wheaton provides research services necessary to support certified opinions of value related to the Fair Market Value and Commercial Reasonableness of transactions related to healthcare enterprises, assets, and services.

Additionally, Ms. Bailey-Wheaton heads HCC's CON and regulatory consulting service line. In this role, she prepares CON applications, including providing services such as: health planning; researching, developing, documenting, and reporting the market utilization demand and "need" for the proposed services in the subject market service area(s); researching and assisting legal counsel in meeting regulatory requirements relating to licensing and CON application development; and, providing any requested support services required in litigation challenging rules or decisions promulgated by a state agency. Ms. Bailey-Wheaton has also been engaged by both state government agencies and CON applicants to conduct an independent review of one or more CON applications and provide opinions on a variety of areas related to healthcare planning. She has been certified as an expert in healthcare planning in the State of Alabama.

Ms. Bailey-Wheaton is the co-author of numerous peer-reviewed and industry articles in publications such as: The Health Lawyer (American Bar Association); Physician Leadership Journal (American Association for Physician Leadership); The Journal of Vascular Surgery; St. Louis Metropolitan Medicine; Chicago Medicine; The Value Examiner (NACVA); and QuickRead (NACVA). She has previously presented before the American Bar Association (ABA), the American Health Law Association (AHLA), the National Association of Certified Valuators & Analysts (NACVA), the National Society of Certified Healthcare Business Consultants (NSCHBC), and the American College of Surgeons (ACS).

Janvi R. Shah, MBA, MSF, CVA, serves as Senior Financial Analyst of HCC. Mrs. Shah holds a M.S. in Finance from Washington University Saint Louis and the Certified Valuation Analyst (CVA) designation from NACVA. She develops fair market value and commercial reasonableness opinions related to healthcare enterprises, assets, and services. In addition she prepares, reviews and analyzes forecasted and pro forma financial statements to determine the most probable future net economic benefit related to healthcare enterprises, assets, and services and applies utilization demand and reimbursement trends to project professional medical revenue streams and ancillary services and technical component (ASTC) revenue streams.

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